



HEALTH INFORMATION REQUEST FORM

I wish to have access to the records of:

Full Name _____

Other names used previously when in Hospital _____

Address _____

Phone Number _____

Date of Birth _____
(to assist in identifying records)

Date of Admission/Discharge _____

Signed _____ ***Date*** _____

In cases where access to records of a deceased person is requested please provide documentation showing you are a personal representative of the deceased person's Estate (ie an executor under his/her Will or appointed as an administrator), or that you have received authority from the personal representative to view the medical file.